

Medical Services: An Overview for Michigan Workers' Compensation

1. INTRODUCTION

What is the purpose of this booklet?

This booklet provides a general outline of billing and payment issues for workers' compensation in Michigan. It is not intended to be a legal document and not intended to cover every possible situation. We hope; however, that it will provide general guidelines for some of the problems that arise. In other situations, providers, carriers, employers, and workers will have to consult with their attorneys for more specific advice.

Specific reimbursement policies are covered within the Health Care Services Rules and the Health Care Services Manual which can be purchased at a cost to cover printing and shipping from the Health Care Services Division of the bureau.

Many billing and payment issues deal with situations resulting from disputes or litigation. It should be pointed out; however, that most billing and payment issues are resolved without disputes, mediation, or litigation.

Accordingly, while this book will try to define the limits of workers' compensation by discussing frequently asked questions, the reader is reminded that this booklet may not address those unusual or extreme circumstances of litigated cases.

The Health Care Services Rules are updated annually through the Administrative Rules Procedure and new questions will come up. You will find instances where all questions are not answered. This booklet; however, will do the best to provide general guidance. **Updated information may be obtained from the bureau website at www.michigan.gov/bwuc.** To get to the rules, click on workers' compensation on the home page and then click on health care services. Both the Health Care Services Rules and the Manual can be downloaded at no charge from the health care services site.

Additional questions regarding the Rules or obtaining a copy of the Rules may be directed to Health Care Services staff at (517) 322-5433.

What are the Health Care Services Rules?

Section 315 of the Worker's Disability Compensation Act of 1969, as amended, requires the bureau to establish maximum fees for medical services. The "Health Care Services Rules" are enacted into law through the Administrative Rules Procedure and includes the following information:

- Guidelines for practitioner and facility billing
- Methodologies for determining the fees
- Rules for carrier reimbursement of medical services
- Requires maximum allowable payments for medical, surgical, and radiology fees published by the bureau in a separate manual or fee schedule.

The Health Care Services Rules do not override information contained within the Workers' Disability Compensation Act.

What medical services do the Workers' Disability Compensation Act and the Health Care Services Rules cover?

The Act covers all medical services, devices, apparatus, or attendance care. When an employee receives a personal injury arising out of and in the course of employment, the employer must furnish or cause to be furnished all reasonable medical, surgical, and hospital services and medicines, or other attendance or treatment recognized by the laws in this state as legal. The employer shall also supply dental service, crutches, artificial limbs, eyes, teeth, eyeglasses, hearing apparatus, and other appliances necessary to cure, so far as reasonably possible, and relieve from the effects of the injury.

What providers are covered under the Health Care Services Rules?

The Health Care Services Rules apply to all licensed providers in Michigan who accept workers' compensation and submit charges to the workers' compensation carrier.

What is the definition of a carrier?

For the purposes of workers' compensation in Michigan, a carrier is defined as an insurance company, a self-insured employer or self-insured group fund, or one of the funds specified in the Act.

What procedure codes are covered services under the Health Care Services Rules or the Health Care Services Manual?

The Health Care Services Rules cite Current Procedural Terminology (CPT) to describe medical, surgical, and radiology services for billing purposes. In addition, the Rules cite Medicare's National Level II Codes, HCPCS, to describe the other ancillary services for billing purposes.

The Health Care Services Division is responsible for publishing and updating the Health Care Services Manual listing the procedure codes and the maximum allowable payments. If a code is not found within the Rules or the Manual, then the provider may bill the appropriate listed code in the most recent edition of either the Current Procedure Terminology or Medicare's National Level II Coding Guide. When a provider bills a code and the Rules or Manual has not established a fee, then the service is "By Report" (BR) and the carrier is required to pay the usual and customary charge or reasonable amount, whichever is less. The Workers' Compensation Act states that the employer must furnish all necessary and reasonable health services, so the carrier cannot deny the service simply because the Rules or Manual do not list the specific procedure code.

Can the provider bill a medical procedure with an unlisted procedure code?

If there is no listed procedure code accurately describing the service found in CPT or HCPCS, the provider may bill the unlisted procedure code. The carrier is required to review the unlisted procedure as a "By Report" (BR) procedure and pay the provider's usual and customary charge or reasonable amount, whichever is less.

Example: If a provider bills 99499, an unlisted evaluation and management code, to describe an office visit, the notes must be included with the bill. Unless the notes substantiate a service different from one of the listed codes for evaluation and management, 99201-99429, it would not be appropriate to use the unlisted procedure code to describe the service.

Can a Michigan worker treat with an out-of-state provider?

A Michigan worker may choose to treat with an out-of-state provider. The employer may direct the care for the 10 days of medical care for a work injury or illness. The Workers' Disability Compensation Act of 1969, as amended, states in Section 315 that 10 days from the inception of medical care, the employee may treat with a physician of his or her own choice by giving to the employer the name of the physician and his or her intention to treat with the physician.

Do these Rules apply to out-of-state providers?

Workers' compensation laws are state-specific and the State of Michigan Health Care Services Rules only apply to employers in Michigan and Michigan workers. In addition, the rules cover providers licensed to practice in Michigan. Michigan law does not regulate providers practicing in states other than Michigan.

A provider located outside of Michigan may choose not to accept the Michigan maximum allowable fees. If the out-of-state provider does not accept the Michigan fee, the carrier must settle the bill with the provider to prevent the injured worker from being balanced-billed. The carrier may attempt to negotiate the outstanding balance with the out-of-state provider and might even take into consideration workers' compensation reimbursement within that state.

What if the worker's employer is located in another state and the worker was not injured in Michigan?

This case would not fall under the jurisdiction of Michigan law unless the employer is doing business as a Michigan company. Workers' compensation laws are state-specific and you need to contact that state for information. The Health Care Services Division has a list of telephone numbers for workers' compensation departments in other states. If you contact workers' compensation in the state where the employer is located, you can find out how to handle the request to settle your bills. Many other states have managed care programs and require prior authorization in order for the services to be covered.

How are complaints submitted to the bureau?

Anyone who is affected by the Health Care Services Rules may submit a written complaint to the bureau regarding the action of any other person who is affected by these Rules. Appropriate documentation shall be included to support the problem and the complaint may be mailed to:

BWUC
Health Care Services Division
PO Box 30016
Lansing MI 48909

2. GENERAL INFORMATION

How long does a worker have to report a work injury and seek treatment?

A worker should notify the employer of an incident, injury, or illness occurring at work as soon as he/she is aware of the incident or injury. A worker has up to 2 years to file a claim under the Worker's Disability Compensation Act.

What if the employee has reported the injury to the employer and the employer has not reported the injury to the carrier.

If the employer will not report the injury, the injured worker should be directed to contact the bureau for instructions on how he/she may report their own claim. **Injured workers may call 1-888-396-5041 or 517-322-1980 for information.**

Is there a filing limitation for a provider to submit charges for a medical service?

A provider must submit charges for medical services to the carrier within 1 year from the date of service. This rule does not apply in cases of litigation or subrogation.

Who is responsible for paying the medical services?

The carrier is responsible for paying properly submitted bills for the medical services rendered to treat a covered work injury or illness.

A carrier is defined as:

- An insurance company
- A self-insured employer
- A self-insured group fund
- One of the funds specified in the Act

What happens if an injured worker pays for a medical service to treat a covered work injury?

When an injured worker pays for a medical service to treat a covered work injury, the worker must send the bill and the receipt for payment to the carrier and the carrier must reimburse the injured worker in full. If the payment made by the injured worker is greater than the maximum allowable payment, the carrier must reimburse the worker in full and may recover the difference or overpayment from the medical provider.

What if a carrier pays for a medical service and later determines the service is not work related or that the service was reimbursed at more than the maximum allowable payment in the Rules?

The carrier has the right to recover payment in accord with the Health Care Services Rules. The carrier would request the provider to refund the payment or the overpayment. If the provider does not respond to the request, the carrier can subtract the amount of the overpayment from any other payment due the provider. When the provider responds to the carrier but does not refund the overpayment, the carrier must file an "Application for Mediation or Hearing" form (104-B) to continue with the recovery of the payment.

What are the responsibilities of the employer?

The employer may direct the injured worker to a treating physician of the employer's choice for the first 10 days of care commencing after an injury or illness. The insured employer is responsible to do the following:

- Promptly file the "Employer's Basic Report of Injury" (Form 100) to the bureau for all wage loss cases.
- \$ Promptly notify its insurer of the medical-only cases.
- \$ Promptly inform the provider of the name and address of its insurer or the designated agent of the insurer to whom health care bills should be sent.
- \$ Promptly forward any medical bills and documentation received for medical services to the insurer.

What are the responsibilities of the injured worker?

The injured worker is responsible for reporting the work-related injury or illness to the employer. In addition, the injured worker may choose their own treating physician after the first 10 days of care for the injury, but the injured worker must notify the employer with the name of the chosen practitioner.

Can the employer or the carrier dispute the employee's choice of treating physician?

The employer or the carrier may dispute the employee's choice of treating practitioners, but the employer or carrier must file an "Application for Mediation or Hearing" form (104B) with the bureau stating the reason for the objection. A magistrate would decide if there was an appropriate reason for the objection.

3. PRACTITIONER INFORMATION

Is the practitioner required to sign up for a provider identification number in order to treat workers' compensation cases?

The Rules do not require a practitioner to obtain a worker's compensation provider number to be able to treat injured workers. Any practitioner licensed by the state may treat injured workers and provide medical services recognized as legal within their scope of practice as defined by Act 368 of the Michigan Public Health Code, as amended.

How is authorization obtained to provide medical services for an injured worker?

Michigan law does not require prior authorization for medical services. The law does allow the employer to direct the care for the first 10 days of medical care, but after 10 days the employee may choose their own treating physician. The carrier must review the billed services and pay those services that are reasonable and necessary to treat the covered work injury or illness.

Are pre-employment physicals covered under the Workers' Compensation Rules?

The service must be performed to treat an injury or illness causally related to employment. With the pre-employment physical there is no employment established; therefore, a pre-employment physical would not be covered under workers' compensation.

Is routine drug screening payable by the workers' compensation carrier?

Routine drug screening would not be covered under workers' compensation. The employer would be responsible for paying the routine drug screening for employees.

How does a practitioner submit a claim for medical services provided to treat a work-related injury?

A practitioner or a health care organization is required to use the standard CMS1500 Claim Form (standard Medicare claim form) when submitting charges for medical services provided to injured workers. The form name changed from HCFA 1500 to CMS 1500. The provider is required to attach any documentation required by the Rules and send it to the carrier.

A health care organization is any of the following:

- \$ Health maintenance organ.
- \$ Clinic including an industrial or occupational clinic
- \$ Home health agency
- \$ Laboratory
- \$ Medical supply company
- \$ Community health board
- \$ Free-standing physical therapy clinic

Other services billed with the CMS (HCFA) 1500 Claim Form are ancillary services such as: ambulance services and orthotic and prosthetic services.

How does the practitioner obtain carrier information if the employer will not give out the name of the carrier?

The employer is required by the Rules to tell the provider the carrier's name and address for billing purposes. If the employer will not provide carrier information, the provider can obtain the information from the bureau's website or the Insurance Division of the bureau by calling (517) 322-1885. The provider will need the following information:

- \$ The employer's name and address
- \$ Date of injury

A listing of the carrier addresses is found on the bureau's website. In addition, this listing may be obtained by contacting the Insurance Division of the bureau.

What documentation is the practitioner required to send with the bills?

The Rules require that practitioners send the following information with the charges:

- \$ A copy of the medical report for the initial visit.
- \$ Progress reports every 60 days of continued care with the same practitioner.
- \$ A copy of the initial evaluation and an updated progress report every 30 days for physical medicine treatment, physical or occupational therapy, or manipulation services.
- \$ The operative report when billing procedure codes 10040-69990. *When a surgical procedure is performed in the office setting, the patient's office notes are included as the operative report documenting the surgical procedure performed in the office.*

- \$ The anesthesia record for anesthesia services billed with procedure codes 00100-01999.
- \$ A copy of the radiology report when billing for the professional component of a radiology procedure.
- \$ Whenever a practitioner bills a service listed as “By Report” (BR) or a procedure that is not listed in the manual.
- \$ A report is required whenever a modifier is added to explain unusual circumstances.

Can a practitioner submit a charge for the copying of records?

The practitioner is required to provide the *initial* copy of the records previously mentioned as required by the Rules at no charge. The Rules state that when a carrier or the carrier’s agent, the worker or the worker’s agent request records for a *specific date of injury*, the provider will be reimbursed in accord with the Rules. The Rules allow 25¢ per page, plus the actual cost of mailing, plus a retrieval fee of \$3.50 for the first 30 minutes and an additional \$3.50 each 30-minute period, or portion thereof, following.

Are signed releases necessary?

The Rules require certain documentation to be submitted with the bill. While procedures may vary in different offices, generally the billing staff has a patient sign a general release stating “this allows us to bill your insurance.” This release will cover the required documentation. You should check with your legal counsel regarding this, but for other documentation not required with submission of the bill you may want to have a specific release signed.

What are the documentation and charting requirements for workers’ compensation?

The requirements are the same as those recommended by the American Medical Association (AMA). The initial evaluation must include a treatment plan, a description of objective findings as well as subjective complaints, and any limitations. If there is a disability or work restriction placed by the provider, that information should be included, as well as anticipated return to work dates. A progress report is required if the worker is still treating with the same provider every 60 days. In addition, a progress report is required every 30 days when physical medicine is being provided. Physical medicine includes manipulation services, physical therapy, and occupational therapy.

Is the carrier allowed to down-code a practitioner’s billed level of service?

A carrier is not allowed to automatically down-code a practitioner’s level of service used to describe a procedure (e.g., evaluation and management service). The Rules require carriers to perform a utilization review of the medical services to determine that the services are appropriate in both the level of service billed and the quality of service provided. The service billed should be appropriate for the diagnosis and the condition of the injured worker. For example, you would not expect to see a comprehensive level of evaluation and management service billed for a minor injury requiring first-aid type treatment. If the documentation provided does not support the level of service billed, the carrier has the duty under the Rules to pay the appropriate level of service. The Rules authorize carriers to withhold or recover payment from health care providers that have made excessive charges, or which have required unjustified treatment, hospitalization, or visits.

How long is a provider required to keep medical records for a workers' compensation patient?

The bureau suggests that you consult your legal counsel. The bureau is required to maintain records for contested cases for 20 years.

In what time frame should the practitioner expect payment?

The Rules state that the provider should receive payment within 30 days. If the practitioner does not receive payment within 30 days of submitting a properly completed bill to the carrier, the Rules say that the carrier must pay the maximum allowable payment, plus a 3% late fee. The late fee due is paid one time and is not compounded.

What should the provider do if they do not receive payment?

If the provider is not paid within 30 days, the provider should re-submit the bill to the carrier marking the bill "DB" for duplicate bill. The provider may add a 3% late fee. If the provider does not receive payment in the next 30 days or a total of 60 days, the provider is instructed to send an "Application for Mediation or Hearing" form (104B) to the bureau. The provider should send the original orange form to the bureau and send a copy to the carrier.

If the provider has never received confirmation from the employer or the carrier that the services were work-related, the provider could bill the injured worker requesting that he/she follow-up with the employer to get the bill paid. *The Rules do not prevent a provider from billing the injured worker. **The Rules only prevent balanced-billing.*** The Rules provide for reimbursing the injured worker in full if the worker pays for a medical service provided for a work-related illness or injury.

What should the provider do if the carrier denies payment because the service is not work-related?

If the provider receives a Carrier's Explanation of Benefits form indicating the service is not work-related, the provider should bill the injured worker. If the injured worker disagrees with the carrier's decision and believes the services *are* work-related, the worker must file a "Plaintiff's Application for Mediation or Hearing" form (104A). The worker generally hires an attorney and the case becomes *contested or in litigation*. If the injured worker does not file a petition for hearing, (Form 104A) to contest the carrier's decision, the denied services become the worker's responsibility.

Can the provider contact the bureau to determine the status of a claim or to learn if a claim has been received?

The bureau does not pay or review bills and the provider must verify the status of the claim with the carrier. A provider must direct all requests for reconsideration of payment to the carrier, not the bureau.

How are dental services billed?

Dental services are covered when the necessary dental procedures are required to correct the effects of a work-related injury. The dental services are billed using standard ADA codes and the Attending Dentist Statement. Procedures for dental services do not have set fees but are considered "By Report" (BR).

What does “By Report” (BR) mean and how does the carrier reimburse “BR” procedures?

“BR” means the procedure does not have a maximum fee assigned and requires a written description. The description shall be included on the bill or attached to the bill and shall list all of the following:

- A simple listing of the service
- The date(s) of the service
- The procedure code
- The charge for the service

“BR” services are reimbursed at the carrier's usual and customary charge or a reasonable amount, whichever is less. A reasonable amount is defined as a payment based upon the amount generally paid in the state for a particular procedure code using available data.

4. CARRIER INFORMATION

Who determines “compensability” for a worker’s compensation claim?

When an employee reports an injury or illness, the insured employer is required to report the information to the carrier. The carrier is required to investigate the claim and determine if the claim is work-related. If the carrier determines the case is not work-related or non-compensable, then the carrier will issue a formal notice of dispute. The carrier is responsible for responding to claims for medical services in 30 days. The Rules require the carrier to send the provider an Explanation of Benefits form for all medical bills received and processed for a worker's compensation case. This form must clearly document the carrier's payment decisions. A copy of the form is also sent to the injured worker for information.

What if the employer has not reported the injury to the carrier?

The carrier could look at the medical bill as notice of injury and still investigate the claim for compensability. The carrier may also return the bill to the provider indicating there is no report of injury on file. In this instance, the provider would bill the injured worker indicating that the carrier has no record of a claim. If the injured worker does not follow through with the employer, he/she may become liable for the provider's charges. If the employer will not report the claim for the injured worker, the worker may contact the bureau and obtain a form from the bureau to report his/her own claim to the bureau. The carrier should also follow-up with the insured employer to determine why the injury was not reported to them.

What is involved in the carrier’s review of medical services?

The carrier is required to pay all necessary and reasonable medical expenses for a work-related injury or illness. The Rules require carriers to perform utilization review using appropriate standards of care for the medical services and reimburse all necessary and reasonable services. It may be the perception of what is reasonable that leads to disputes in workers' compensation. A carrier may review medical bills in-house or contract with a vendor to review the medical bills. *The carrier must notify the provider where the bills are to be sent.* The carrier's review process consists of technical (computer-review) and professional review.

The Health Care Services Rules mandate that carriers have licensed healthcare professionals involved in the utilization process to ensure that the services are necessary and reasonable

and related to the work injury or illness. The Rules require professional review be performed when:

- Medical payments for a case (excluding inpatient care) exceed \$5,000
- There is inpatient hospital care
- Any case that the carrier deems necessary to review

What if the carrier does not pay the bill for medical services within 30 days?

If the provider's bill was properly completed and the required documentation was attached, the carrier is required to pay the provider within 30 days or pay a 3% late fee.

How does the carrier dispute a medical service?

The carrier will use the "Carrier's Explanation of Benefits" form to notify a provider of payment or to dispute a medical service. The Explanation of Benefits form should clearly explain the carrier's determination for reimbursement or reason for not paying the medical service. The carrier may also send out a Formal Notice of Dispute (bureau Form 107) to the injured worker notifying the worker of the dispute.

5. DISPUTES

What if the carrier determines the worker's compensation claim is not compensable or work-related?

A carrier has the responsibility to investigate a worker's claim of an injury or illness and determine compensability of that claim. When the carrier determines the claim is not work-related, the carrier must notify the employee and the employer on a "Formal Notice of Dispute" (Form 107). While law does not require it, it is helpful if the carrier also notifies the treating providers by sending a copy of this form.

If the carrier notifies the provider on the Explanation of Benefits that the service is not work-related, does that mean the case is contested?

Not necessarily. A case does not become contested until the injured worker receives the formal notice of dispute and responds to the dispute by filing an "Application for Mediation or Hearing" form (104A) with the bureau. Once the worker files the "Application for Mediation or Hearing" form (104A), the case becomes contested.

Upon receipt of the Carriers' Explanation of Benefits form stating, "service is not work-related" the provider should then bill the injured worker. Upon receipt of the provider's bill, the injured worker should then do one of the following:

- Pay the bill or ask the provider to bill the health insurance.
- Inform the provider that the case is work-related and the case is in litigation.
- If the worker has not already filed for a hearing to dispute the carrier's denial, he/she should file the 104A if they believe this is workers' compensation.

If the carrier is not required to send a copy of the 107 Form to the provider, how is the provider supposed to be notified?

The Health Care Services Rules do require that the carrier respond to the provider's bills with a "Carrier's Explanation of Benefits" form (BWC-739). If the carrier does not send the provider a copy of the formal notice of dispute, the carrier must send out a notice by the "Carrier's Explanation of Benefits" form explaining that the services are not being paid because the claim is in litigation. Once the carrier notifies the provider that the claim is in litigation and the bills will not be paid, the carrier is not required to respond to further bills by the same provider.

What should the provider do when they become aware that the case is in litigation or in dispute?

The provider should file an "Application for Mediation or Hearing" form (104B), with the bureau requesting the bureau to add the provider as an intervening party. When the provider files the 104B, the magistrate addresses the disputed medical payments at the time of trial. The provider should also send copies of any unresolved medical bills to the injured worker or to the injured worker's attorney so they understand what medical services are outstanding in case of any out-of-court settlement. When the case is contested, the carrier will not pay for any ongoing services.

6. FACILITY INFORMATION

How do hospitals and other facilities submit their charges for workers' compensation cases?

A facility must submit their charges on the standard facility UB-92 claim form. The facility must complete the claim as instructed in the UB-92 Billing Manual that may be obtained from the Michigan Health and Hospital Association. The manual may be ordered by calling (517) 886-8357.

What facilities are able to submit charges for workers' compensation medical services?

Facilities licensed by the state of Michigan may submit facility charges for work-related services provided to treat an injured worker. A listing of licensed facilities may be obtained from the Bureau of Health Systems, PO Box 30664, Lansing, MI 48909, or by calling (517) 241-4153. **A physician's office is not a facility.**

How are facilities reimbursed?

A hospital is reimbursed for certain services such as emergency department services, inpatient services, outpatient surgery, physical medicine services, and laboratory services by a cost-to-charge ratio methodology outlined in the Health Care Services Rules and the Health Care Services Manual. For other minor services, such as clinic visits or radiology services, the hospital is reimbursed for only the technical component of the maximum allowable payment listed in the Manual.

When a hospital bills for practitioner services, the practitioner services must be billed on the CMS (HCFA) 1500 claim form. The Rules have specific guidelines for paying practitioner services. A hospital-owned occupational or industrial clinic must be billed as a practitioner service on the CMS (HCFA) 1500 claim form.

A facility other than a hospital is reimbursed at the provider's usual and customary charge or reasonable amount, whichever is less.

What determines a hospital's ratio listed in the Rules?

The bureau calculates the ratio using a hospital's most recent fiscal year-ending information that is submitted to the Department of Community Health, Medical Services Administration. The bureau uses this data from the Department of Community Health and calculates the maximum payment ratio for each hospital. This calculation is done between September 1 and October 1 of each year. The hospital ratio information is published in the Health Care Services Manual. In addition, the updated hospital payment ratios will be published on the Internet on the bureau website each year by mid-October.

If a hospital disagrees with the published ratio and has data available from a more recent fiscal year ending, the hospital may obtain a form from the bureau and submit the form along with the most recent data on the G-2 worksheet to the bureau requesting reconsideration of the payment ratio. The bureau will review the information submitted and adjust the hospital's payment ratio when criteria listed in the Rules is met.

7. WHO TO CONTACT FOR QUESTIONS OR INFORMATION

Bureau of Workers' Disability Compensation

7150 Harris Drive
PO Box 30016
Lansing MI 48909

Web Site: www.michigan.gov/bwuc

Toll free (888) 396-5041

TDD in Lansing (517) 322-5987

Customer Service	(517)-322-1980
Insurance Programs	(517) 322-1195
Employer Compliance	
Insurance Coverage	(517) 322-1885
Self-Insurance	(517) 322-1868
Vocational Rehabilitation	(517) 322-1721
Claims Processing	(517) 322-1438
Health Care Services Division	
Sheila Wilkinson, Administrator	(517) 322 5896
Carrier's Certification of Review	(517) 322-5430
General questions	517) 322-5433

Mediator Locations

Detroit	Cadillac Place 3026 W Grand Blvd., Suite 3-700 Detroit MI 48202 (313) 456-3650
Escanaba	State Office Bldg. 305 Ludington St. Escanaba MI 49829 (906) 786-2081
Lansing Area	2501 Woodlake Circle Okemos 48864 (517) 241-9393

Appellate Commission 1375 S. Washington Avenue PO Box 30468 Lansing MI 48909 (517) 335-5828	Board of Magistrates PO Box 30016 Lansing MI 48909 (517) 241-9380
--	---

Funds Administration	
7201 W. Saginaw Suite 110 Lansing MI 48917 (517) 323-2444	Funds Include: Second Injury Fund Self-Insurers' Security Fund Vocationally Handicapped Fund Silicosis, Dust Disease, and Logging Industry Compensation Fund

Bureau of Workers' Disability Compensation- Lansing	
Application for Hearing, 104B or Carrier Response Forms	Contested Case Section (517) 322-5991
Forms BWC-100 or BWC-701	Claims Processing: Technical Support (517) 322-1438
General Information or Questions from Injured Workers	Customer Service (517) 322-1980 or (888) 396-5041
Disability Management or Vocational Rehabilitation	David Campbell (517) 322-1721
Freedom of Information (FOI)	Claims Processing (517) 322-5937
Experience Modification	(734) 462-9600
Self-Insured Employers; Listing of or Information	Self-Insured Programs (517) 322-1868
Carrier Information Listing of all Carriers	Employer Records (517) 322-1885 Compliance (517)-322-1195